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Impulsiveness and dysphoria as pharmacological targets: Can we aim at a phenomenologically informed therapeutic intervention?

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ABSTRACT

Dysphoria and impulsivity are states that are described across a range of psychiatric disorders. However, current diagnostic systems like the DSM and ICD, along with traditional psychiatric literature, often overlook the subtle, embodied nuances of these phenomena. The reliance on standardized psychometric scales and efficacy-based guidelines in choosing medication circumvents a more personalized approach within a phenomenological framework that integrates clinical judgment with a deep understanding of patients' embodied experiences. This paper proposes a phenomenologically informed approach in relation to understanding and targeting dysphoria and impulsivity in pharmacological interventions. While one may be inclined to use a specific medication based on label information, the effect on a person's embodied experience can vary significantly. Additionally, the same medication may change the experience of impulsivity or dysphoria in one person in a completely different manner than in another person, which raises the possibility that medications may have their own "phenomenological profiles". Another important aspect is the role of intersubjectivity in the clinician-patient relationship. By modulating the patient's affective responses and facilitating a more balanced sense of self, medication might allow for a deeper, clearer articulation of their lived experience during clinical encounters. Ultimately, I argue for a more nuanced, phenomenologically informed approach to pharmacological intervention. Integrating the patient's lived, embodied experience with an understanding of the subtle effects of medication can enhance clinical judgment and potentially lead to more effective, personalized treatments.

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Both dysphoria and impulsivity serve as markers across a wide array of disorders — including depression, bipolar disorder, addictive disorders, and schizophrenia — yet current diagnostic manuals such as the DSM and ICD, as well as conventional psychiatry textbooks, often fail to capture their subtle, embodied nuances.

I argue that dysphoria and impulsivity are best understood as embodied responses, viewed through a phenomenological lens that emphasizes individuals' lived, subjective experiences. Namely, dysphoria is traditionally described as a state of unease or dissatisfaction — often so profound that unexplained medical (i.e. bodily) symptoms may actually reflect this deeper discontent (Oyebode, 2022). Likewise, impulsivity is characterized by rapid, unplanned reactions to internal or external stimuli, frequently overriding reflective thought and disregarding potential negative consequences (Moeller et al., 2001). The bodily manifestations

of impulsivity are experienced as an overwhelming urge to act — where immediate physical responses eclipse the slower processes of deliberation and reflection (Herman et al., 2018).

> "As I was at the Y talking to my buddy, who is 55, he reached for a pill bottle, took out a 2-mg tablet of Abilify, a psychiatric drug, and swallowed it. 'This has changed my life', he said. By 5 pm each day he used to storm around ready to hit someone, loud, full of fury, and he experienced several arrests and an inability to keep himself from yelling at the cops. Now, he says, 'This has given me my life back. I'm normal again'. So, treating mental illness with drugs — psychopharmacology — really can work. The drugs are often highly effective. But what did my friend have? Mania or hypomania? He wasn't euphoric, had no flight of ideas, no hyperactivity, and certainly no psychosis. He was just chronically angry and agitated. That's not in the DSM, the diagnostic bible of psychiatry. And chronic anger is not one of the official indications for Abilify either, which was launched as an 'antipsychotic'. Abilify is now also indicated for 'bipolar disorder'. My friend had neither psychosis nor bipolar disorder. Yet, his clinician had the good judgment to prescribe the drug. So, in my friend's case, psychopharmacology was effective, but the official side of it — diagnoses and treatments — was nonsense." (Shorter, 2021).

This is how Edward Shorter, the famous historian of psychiatry opens one of his books. The initial problem of the person in question can easily be construed as both dysphoria and impulsivity. How did the psychiatrist know which medication would likely help Shorter's friend? Is it possible to somehow systematically target elusive experiences such as dysphoria and impulsivity? If so, what frameworks can be employed to achieve this?

I contend that pharmacological interventions may benefit from a phenomenologically informed approach — one that considers not only the reduction of patients' symptoms as representatives of ICD/DSM diagnoses but also the broader, embodied impact of medications. By aligning clinical judgment with a deeper understanding of how dysphoria and impulsivity manifest in the body and the lived experience of a person, we can aspire to develop more effective, targeted treatments.

In current clinical practice, the detailed phenomenological assessment of patients is often sidelined due to constraints on time and the specialized training required. As a result, clinicians typically rely on assessments based on psychometric scales, which are, in turn, informed by standardized guidelines, which are primarily based on efficacy data. Thus, clinical guidelines recommend pharmacological interventions based on efficacy from randomized controlled studies. To be fair, most treatment guidelines explicitly state that decisions should be made according to clinicians' own clinical judgment and patient preferences. This pragmatic approach, however, tends to overlook the rich, embodied experiences of dysphoria and impulsivity.

Thus, clinicians are confronted with the task of targeting an inherently "unclear" embodied experience with an agent whose own phenomenological impact may not be fully understood. This scenario necessitates a careful balancing act — integrating clinical judgment with an appreciation of both the patient's lived experience and the subtle, embodied effects of medications. Only by acknowledging these dimensions can therapeutic interventions be truly aligned with the unique needs of each individual.

One possible avenue of phenomenologically based thinking is that medications, much like the patients themselves, may come with their own "phenomenological profiles". For instance, while one might be inclined to use a specific medication based on label information, such as an SSRI for dysphoria in depression or quetiapine for dysphoria in bipolar disorder, the actual effect on a patient's embodied experience can vary significantly. To make things more

complicated, the same medication may have completely different effects in different patients with the same disorder. Valproate may change the experience of impulsivity in one patient in a completely different manner than in another patient.

Another important facet of the phenomenological theory relevant to psychopharmacology is intersubjectivity. Intersubjectivity refers to the mutual, reciprocal connection and understanding between individuals. It is a concept central to phenomenology, emphasizing how individuals share, interpret, and engage in each other's lived experiences. This is of paramount importance for the discussion of medication and its effects on states such as dysphoria and impulsivity since the embodied self, which is the medium of intersubjective connections, is modified through these drug-induced changes, thereby reshaping the intersubjective space. While a well-argued critique has been made by Brencio (2024), detailing how altered state of consciousness induced by medication may detrimentally impact the clinician-patient interaction, I argue that the opposite may be true as well. Clinical encounters, as described by Brencio, occur in shared atmospheres charged with affective qualities. Medications may alter these atmospheres by changing the patient's and clinician's affective and embodied engagement with the shared space, influencing the therapeutic relationship and the broader social environment in a positive manner. For example, in patients experiencing dysphoria or impulsivity, medication may stabilize the chaotic internal states that otherwise hinder their ability to engage in meaningful intersubjective connections. By modulating the patient's affective responses and facilitating a more balanced sense of self, medication might allow for a deeper, clearer articulation of their lived experience during clinical encounters. This clearer articulation benefits both the patient and the clinician, enabling a richer understanding of elusive experiences like dysphoria and impulsivity. Dysphoria, often characterized by an ambiguous sense of unease and dissatisfaction, can be difficult to verbalize or grasp in its fullness. Similarly, impulsivity may lead to fragmented interactions that obscure the patient's underlying experiences. Medications, by grounding the patient's affective and cognitive processes, create an opportunity for these phenomena to be explored within the intersubjective space. In this way, medications can not only alter the individual's internal states but also enhance the relational dynamics of the clinical encounter, making the elusive more accessible.

The clinical use of SSRIs provides a compelling example of the intersection between pharmacology and phenomenology. Traditionally, clinical guidelines suggest that when an antidepressant is indicated, an SSRI in its generic form is preferred due to its comparable efficacy and favorable risk-benefit ratio. However, the lived experiences of patients taking SSRIs reveal a more nuanced story.

In an empirical phenomenological study performed by Teal (2009), several persons described their subjective experience shortly after starting an SSRI. One person noted, "If a situation was stressful or upsetting or exciting, I could feel something holding me back slightly, like a hand on my shoulder, forcing me to give the situation a bit of distance." Another person recounted, "The immediate contrast when I first took Prozac was so profound... my heart chakra, physically relaxed, and my chest felt so calm." These evocative descriptions illustrate how the medication not only alleviates symptoms but also reconfigures the embodied experience of distress (Teal, 2009).

This phenomenological change — characterized by a sense of increased distance or disconnection from one's emotional and bodily realms — highlights an essential aspect of SSRIs that is often overlooked in standardized efficacy assessments. Understanding this embodied effect allows clinicians to appreciate the underlying phenomenological disturbance better and, in turn, refine their therapeutic decision-making. By taking into account both the tangible, bodily alterations and the subjective narratives of patients, SSRIs can be seen as more than just a chemical intervention; they become a means of reshaping the fundamental experience of being.

Taking everything into account, the examination of dysphoria and impulsivity through a phenomenological lens reveals that these mental states are deeply embodied phenomena. Dysphoria is not merely an abstract feeling of unease but is anchored in tangible bodily sensations such as chest constriction, fatigue, and muscle tension. Similarly, impulsivity emerges not just as a behavioral pattern but as an embodied urge that bypasses reflective thought. Current diagnostic frameworks and treatment guidelines often overlook the complex, lived realities of patients, relying instead on standardized assessments and generalized efficacy data. As a result, clinicians face the challenge of matching ambiguous, embodied experiences with medications whose own phenomenological profiles remain inadequately characterized.

Ultimately, I argue for a more nuanced, phenomenologically informed approach to pharmacological intervention. Integrating the patient's lived, embodied experience with an understanding of the subtle effects of medication can enhance clinical judgment and potentially lead to more effective, personalized treatments.

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